NEW JERSEY RETIREE DENTAL PLANS APPLICATION

Division of Pension and Benefits, P.O. Box 299,Trenton, NJ 08625-0299

1. RETIREE INFORMATION-This section must be filled out completely. Please print or type.

Social Security Number

Last Name | Title (Jr., Sr., etc.)

First Name | MI

Street Address (Include Apartment #)

City | State

ZIP Code + 4 | Date of Birth (mm/dd/yy) | Gender (M/F)

Status:

☐ -Single ☐ -Married ☐ -Civil Union ☐ -Domestic Partnership ☐ -Divorced ☐ -Widowed

Are you transferring from another SHBP/SEHBP participating employer? ☐ Yes ☐ No

(Area Code) Home Telephone Number

If yes, name of employer: _____

2. DENTAL COVERAGE

2a. RETIREE SELECTION

☐ I wish to be covered under the Dental Expense Plan. (Aetna DEP) ; or

I wish to be covered under a Dental Plan Organization (DPO).

☐ Aetna DPO ☐ Healthplex

☐ Cigna ☐ Horizon BCBSNJ

☐ MetLife

Dentist Name/Provider ID#:_____

☐ I am changing dental plans only:

From:_____ _____

To:_____

☐ I elect to waive dental coverage in any dental plan (see instructions).

2b. LEVEL OF COVERAGE

☐ Single ☐ Member and Spouse/Civil Union Partner

☐ Member and Domestic Partner (see instructions)

☐ Family ☐ Parent and Child(ren)

2c. PREVIOUS DENTAL COVERAGE

Were you enrolled in a group dental plan for at least 12 months prior to now?

☐ Yes ☐ No

If yes, please provide:

Dental Plan Name_____

Telephone Number_____

Your Dental Plan ID Number_____

FOR DIVISION USE ONLY

Event Reason | Effective Date

Waiver Code | Location No.

3. DEPENDENT INFORMATION - List only eligible dependents and attach required proof of dependency documents (see instructions on reverse).

Spouse/Civil Union/Domestic Partner Last Name	First Name	MI	Date of Birth (mm/dd/yy)	Gender (M/F)	Social Security Number	Name of Dependent's Dentist or ID#	
Children							
							Natural (C)
							Adopted (A)
							Foster (F)
							Step (S)
							Legal Ward (L)

(See Instructions)

4. TYPE OF ACTIVITY

(complete only if requesting changes to existing coverage)

4a. ADDITION OF DEPENDENT

(attach required proof of dependency documentation)

☐ Marriage

Date of Event (mm/dd/yy) _____

(attach Marriage Certificate and supporting documents)

Former Name _____

☐ Civil Union/Domestic Partner - Date of Event (mm/dd/yy) _____

(attach Certificate of Civil Union or Domestic Partnership and supporting documents)

☐ Birth of Child (attach supporting documents)

☐ Adoption/Guardianship - proof required

Date of Event (mm/dd/yy) _____

4b. DELETION OF SPOUSE OR PARTNER

☐ Divorce ☐ Dissolution of Civil Union

☐ Termination of Domestic Partnership ☐ Death

Date of Event (mm/dd/yy) _____

4c. DELETION OF CHILD

☐ Deletion of Child -

Date of Event (mm/dd/yy) _____

Child's Name _____

Child's SSN _____

Give Reason _____

4d. OTHER CHANGES

☐ Change in last name only

(Attach copy of supporting documentation)

(List former name) _____

☐ Change in Soc. Sec. #

(Attach copy of Social Security card)

(List former Soc. Sec. #) _____

☐ Change in Birth Date

(Attach copy of birth certificate) (List name and correct date)

_____

☐ Other - give reason (i.e., address change, dependent returns from military service)_____

_____

5. CERTIFICATION - I certify that all the information supplied on this form is true to the best of my knowledge and that it is verifiable. I understand that if I waive my right to coverage at this time, enrollment is not permissible unless other coverage is lost and proof of loss is provided (HIPAA). I understand that I must remain enrolled in the Dental Plan for a minimum of 12 months and that there is no guarantee of continuous participation by dental service providers, either dentists or facilities in the DPO plans. If either my dentist or dental center terminates participation in my selected plan, I must select another dentist or dental center participating in that plan to receive the benefit. I authorize any hospital, physician, dentist, or dental care provider to furnish my dental plan or its assignee with such dental information about myself or my covered dependents as the assignee may require.

Misrepresentation: Any person that knowingly provides false or misleading information is subject to criminal and civil penalties.

Signature _____

Date Completed _____

INSTRUCTIONS FOR THE RETIREE DENTAL PLANS APPLICATION

- **To enroll** for the first time complete all sections of the application with the exception of "Division Use Only" box.
- **To change dental plans only** complete sections: 1, 2a and 2b (if enrolling in a DPO be sure to select the name of your plan), 3 (listing all eligible dependents), and 5.
- **To change coverage level** (adding/deleting dependents) complete sections: 1, 2a and 2b, 3 (listing all eligible dependents), 4 (listing why you are changing coverage level), and 5.
- **To add a dependent** complete sections: 1, 2a and 2b, 3 (listing all eligible dependents), 4a, and 5. You must also attach the required proof of dependency documents.
- **To terminate/decline coverage** complete sections: 1, 2a, and 5. If you are declining enrollment for yourself or any or all of your eligible dependents because of other group dental insurance coverage, you may in the future be able to enroll yourself and/or your eligible dependents in a dental plan, provided that you request enrollment within 60 days after your other group health coverage ends.

SECTION 1 - RETIREE INFORMATION

This section is completed in its entirety each time an application is submitted. The retiree enrolling/enrolled in the plan completes this section.

SECTION 2 - DENTAL COVERAGE

2a. Check only one box indicating the dental plan you wish to be enrolled in. If you do not want dental coverage or wish to cancel coverage, check the box to waive coverage.

NOTE: Once you decline or cancel Dental coverage, enrollment is not permissible until the next open enrollment period or if other coverage is lost and proof of loss is provided (HIPAA).

2b. If electing coverage, check the level of coverage desired. (No employee or dependent can be covered under more than one Dental Plan.)

NOTE: Once enrolled, you and your eligible dependents must remain in the plan you elect for a minimum of 12 months before you can switch plans. You may cancel coverage at any time.

2c. If electing coverage, indicate if you were formerly enrolled in a dental plan for 12 months. If so, please indicate plan name, telephone number, and dental plan identification number.

SECTION 3 - DEPENDENT INFORMATION — Only eligible dependents may be listed. Completion of this section is essential for proper enrollment. Be sure dependents listed agree with the level of coverage selected in sections 2b. List the name, date of birth, gender, and Social Security number of the family members you wish to be covered under the plan. You may list an eligible spouse, civil union partner, or same-sex domestic partner, and your children under age 26.

SPOUSE: This is a person to whom you are legally married. A photocopy of the *Marriage Certificate* **and** a photocopy of the retiree's most recent Federal tax return* that includes the spouse are required for enrollment.

CIVIL UNION PARTNER: This is a person of the same sex with whom you have entered into a civil union. A photocopy of the New Jersey *Civil Union Certificate* or a valid certification from another jurisdiction that recognizes same-sex civil unions **and** a photocopy of the retiree's most recent NJ tax return* that includes the partner are required for enrollment. The cost of civil union partner coverage may be subject to federal tax (see your employer or Fact Sheet #75, *Civil Unions,* for details).

DOMESTIC PARTNER: This is a same-sex domestic partner, as defined under Chapter 246, P.L. 2003, the Domestic Partnership Act, of any State employee, State retiree, or an eligible employee or retiree of a SHBP or SEHBP participating local public entity if the local governing body adopts a resolution to provide Chapter 246 health benefits. A photocopy of the New Jersey *Certificate of Domestic Partnership* dated prior to February 19, 2007 or a valid certification from another jurisdiction that recognizes same-sex domestic partners **and** a photocopy of the employee's most recent NJ tax return* that includes the partner are required for enrollment. The cost of same-sex domestic partner coverage may be subject to federal tax (see your employer or Fact Sheet #71, *Benefits Under the Domestic Partnership Act,* for details).

***Note:** On tax forms you may black out all financial information and all but the last 4 digits of any Social Security numbers.

CHILDREN: This is your child age 26 or under. A photocopy of a child's birth certificate showing the name of the employee as a parent is required for enrollment. In addition, if you have listed a child who is an adopted child, foster child, stepchild, legal ward, has a different last name than the retiree, or if the member has a Parent/Child contract, additional supporting documentation is required. If you have more than two eligible dependent children, attach a separate application and complete Sections 1, 3, and 5. For all dependents, include the dentist's name or identification number. All dependents must have this information listed. Refer to the DPO directory for this information or call the dental plan directly.

NOTE: If you are deleting dependents, do not list them in this section. Refer to section 4b and 4c.

SECTION 4 - TYPE OF ACTIVITY

4a. If you are adding a dependent, check the appropriate box, indicate the event date, and attach required proof of dependency documentation.

4b. If you are deleting a dependent spouse, civil union partner, or domestic partner, check reason and indicate the event date.

4c. If you are deleting a dependent child, indicate the event date, list the child's Social Security number, and give reason.

4d. For other changes, check the appropriate box, give requested information, and attach a copy of supporting documentation if applicable.

SECTION 5 - CERTIFICATION

You must read the Certification statement, **sign it, and date the application.**

Misrepresentation: Any person that knowingly provides false or misleading information is subject to criminal and civil penalties.